Telehealth and TelephoneTriage

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Giving credit. . . .

The material in this presentation has been tailored specifically for nurses who care for individuals with intellectual & developmental disabilities by
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in consultation with
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Learning Objectives

Upon completion of this seminar, you will be able to:

- Define the various forms of telehealth
- Describe the role of the nurse in telephone triage
- Identify the role of protocols in telephone triage
- Conduct a meaningful interview by phone
- Document to increase quality and decrease risk

What is Telehealth?

- A broad variety of technologies and tactics to deliver virtual medical, health, and education services.

- NOT a specific service, but a collection of ways to enhance care and education delivery.

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Knowing the terms

- Telehealth
  - The delivery of preventative, promotive and curative aspects of health
- Telemedicine
  - medical diagnosis of patients' problem and their medical treatment over the phone by physicians
- Telephone Triage
  - Estimating symptom urgency to get the patient to the right place, at the right time, for the right reason

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Telehealth Modalities

- Live (synchronous)
  - "real time"
- Store-and-forward
  - Transmission of recorded health history (for example, pre-recorded videos and digital images such as x-rays and photos)
- Remote Patient monitoring
  - collect and transmit data from an individual in one location to a provider in a different location

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Telemedicine

- A subset of telehealth
- The evaluation, diagnosis and treatment of illness by an authorized provider (MD, PA, NP) at a distance using telecommunications.
- Allows clinician to talk directly to their patients in real time

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Telephone Triage

- Oldest form of "live" telehealth
- Practiced since the 1980's
- An interactive process between a
  nurse and a caller that occurs over the
  telephone
- Involves identifying the urgency of person's
  healthcare needs and directing him/her to the
  appropriate level of care

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Why Do Telephone Triage?

Provides for improved quality of care for persons we support.

Provides professional direction and support for unlicensed direct care staff.

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Does Telephone Triage work?

A 2015 article in the *Journal of the American Board of Family Medicine* concluded that "Implementation of nurse phone care was associated with lower inappropriate antibiotic usage and fewer unnecessary provider visits."

Pittinger et al, 2015

What is the Purpose of Telephone Triage?

To estimate symptom urgency to allow the nurse to direct the individual
- ✓ to the right level of care,
- ✓ at the right place
- ✓ at the right time
- ✓ with the right provider

so that s/he receives the optimum treatment

No diagnosing here

- Does not involve making either nursing or medical diagnoses
- Recognize and match symptoms to those in a protocol
- Assign acuity

Diagnosis

Decision Making in Conditions of Uncertainty

Self Doubt Associated with Decision Making is a Characteristic of Expertise

Pat Benner (1984)

Why Special Training for Telephone Triage?

- Study of 35 adolescent care clinics

- Simulated triage calls
  - Adolescent actress
  - R/O ectopic

Rupp, Ramsey, Foley (1994)

Findings:

- > 1/3 gave inappropriate advice
- < 1/3 of advice given by RN

- No difference in the quality of advice given by an RN and a secretary!!!

What Can We Do About It?

- Knowledge deficit
- Being rushed
- Underestimating the risk
  - (It's on the phone, so it 's not serious!)
  - Frequent flyers
  - Aid-initiated diagnosis
- Fatigue
- Multitasking

- Protocols; STUDY!
- Slow down! Use protocol
- Look for urgents
  - (all are life threatening until proven otherwise)
  - Even they can get sick!
  - Run the other direction!!!
- Share/rotate call
- Take time to "shift gears"
- Make strong efforts to concentrate on each call

Points to consider

American Healthcare Accreditation Commission-URAC standards
- Staff must be properly trained RNs or MDs
- Must call back within 30 minutes
- If using automated system, must connect to "live" person within 30 seconds
- Must use decision support tools
- Must document all calls
- Must provide for /ensure continuity of care

Nurse Practice Issues

In general, only RNs may conduct patient assessment

- LPN
  - In 2005 the NCSBN found there was general agreement among states that LPNs cannot do telephone triage

  - LPNs may not assess independently

  - Works under supervision of RN or MD

Role of the On-Call Nurse

- Assessment

- Advice / Treatment

- Occasionally
  - Message taker
  - Appointment/referral

Patient Assessment Over the Phone

And why are you calling today?

Why Are You Collecting the Data?

- Establish Urgency

- Protocol selection

- Communicate with provider

- Document the encounter with the aide

Types of Decision Making

- Pattern Recognition
  – Immediate response behavior

- Focused
  – Limited problem solving

- Deliberative
  – Deliberate problem solving

Opening the Call

- Set tone
  – Unhurried, caring, concerned
  – Establish rapport quickly
- Staff will generally tell you
  – Who they are
  – What residence they are calling from
  – Who the individual is they are calling about
  – Why they are calling

First things first

- Ask if there is any problem with
  - Airway/breathing
  - Circulation
  - Neuro Deficit (altered level of consciousness
  - Affect (not himself? Different from baseline?)

Moving In On the Problem

- Isolate Chief Complaint
  - Become more focused based on hypothesis
- Establish urgency
  - If caller is concerned, take them seriously

Mnemonic to help you remember

"OLD CART"
- O=Onset
- L = Location
- D=Duration
- C=characteristics
- A= aggravating factors
- R=relieving factors
- T=treatment

Things staff should know

All staff should be trained in objective measures:
- Vital signs
- Pulse oximetry
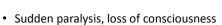- Fingerstick blood glucose

When calling staff need:
- Vital signs already done
- MAR
- Date of last MD appointment

Nursing Process

- Assessment
  - Subjective, Objective, Conclusion (Triage category)
- Planning
  - Collaboratively—leave some responsibility with aide
- Implementation
  - Continuity!
- Evaluation
  - Know before you hang up—"let's talk again…"

Emergent Presentations

- Sudden paralysis, loss of consciousness
- Sudden loss of vision
- Crushing chest pain
- Severe difficulty breathing, stridor
- Sudden onset severe abdominal pain
- Sudden onset cold, pale extremity
- Penetrating trauma of head or thorax
- Suicidal ideation with plan & means to carry out
- Testicular pain and/or swelling

Emergent Presentations

- **Sudden** paralysis, loss of consciousness
- **Sudden** loss of vision
- **Severe** or crushing chest pain
- **Severe** dyspnea, stridor
- **Sudden** onset **severe** abdominal pain
- **Sudden** onset cold, pale extremity
- Penetrating trauma of head or thorax
- Suicidal ideation with plan & means to carry it out
- Testicular pain or swelling

Urgent Presentations

- Worse headache of life
- Pink eye with pain or decreased acuity
- Uncontrolled severe high blood pressure
- Severe cough, fever, weakness
- Acute onset mild abdominal pain
- Blunt extremity trauma with pain
- Seizure – new presentation/type

Non-urgent Presentations

- Typical previously diagnosed migraine
- Mild sore throat without other symptoms
- Sinus congestion without red face or eye
- Cough, fever, no chest pain, feels OK
- Uncomplicated rash or bee sting
- Dysuria
- Usual seizure pattern/type
- Limited, short-term vomiting or diarrhea

Telephone Triage Protocols
(Decision Support Tools)

Protocols…
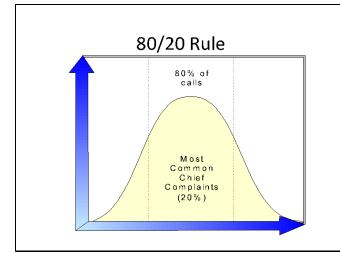
- Clinical rules for handling calls and giving advice

- Guide the nurse in decision making

- Should allow for structure without being inflexible

- Should NEVER supercede nursing judgment

Protocols Avert Disaster

- Decrease likelihood of overlooking important facts
  - Function as a checklist to prevent oversights
  - Will help a busy nurse focus
- Supplement knowledge deficits
- Standardize approach to the problem
  - Day to day
  - Nurse to nurse
  - Patient to patient (protects "frequent flyers")
- Decrease ambiguity in decision making
  - (Provide a tangible basis for decision-making)
- Represent the standard of care
  - Recommended by professional organizations
  - Are widely cited in nursing literature

Proper Use of Protocols

- Complete initial assessment BEFORE opening the protocol (to assure proper protocol selection)
  - Patients frequently call with most worrisome associated symptom (not chief complaint)
  - Patients frequently self-diagnose wrong!
- Review all appropriate protocols, take highest level action recommended
- Protocols don't represent artificial intelligence; Deviate (*and document*) when it's indicated

80/20 Rule

80% of calls

Most Common Chief Complaints (20%)

Types of protocols

- Prescriptive
  - Give specific directions for action
  - Leave little or no flexibility
  - Generally easy to use with little or no instruction
- Flexible
  - Give directions within a range of possibilities
  - Leave flexibility for nurse to develop plan of action
  - Sometimes require specific instruction in use

Things to Consider

- Experience of RN staff who will be using them
- Ease of use
- Portability
- Adaptability to MR/DD population
- Cost

Role Play

7:30 AM

You receive a phone call

"Hello! Charlie started coughing while eating breakfast"

What would you ask?

Choking & Aspiration Protocol (Example)

Key Questions: Name, Onset, Cause, Prior History, Pain Scale

➤ ASSESSMENT

A. Is the following present? ➤ The person is unconscious and not breathing	**Yes-Call 911 an start CPR!** **No – Go to B**
B. Is the following present? ➤ conscious but unable to speak, cough or breathe?	**Yes-Call 911 ar start first aid** **No – Go to C**
C. Are any of the following present? ➤ Difficulty Breathing ➤ Blue lips or face	**Yes-Call 911** **No – Go to D**
D. Are any of the following present? ➤ Foreign body aspirated into lungs ➤ Coughing up blood or severe pain after dislodging foreign body from throat ➤ Unable to remove foreign object from throat and no other symptoms	**Yes-Call 911** **No – Go to E**

Choking & Aspiration Protocol (Example, Con't)

E. Are any of the following present?
- Able to speak and cough
- No difficulty breathing
- Frequent episodes of choking on saliva, foods, or fluids

YES Call back or call PCP for appointment if no improvement and follow Home Care Instructions

NO Follow Home Care Instructions or Agency Protocol

HOME CARE INSTRUCTIONS: CHOKING
- For frequent choking, eat slowly and take smaller bites
- Allow time for swallowing between bites of food and fluid consumption.
- Ensure the person is in the proper eating position and that the mealtime protocol is being used.
- Ensure that the proper adaptive equipment is being used.

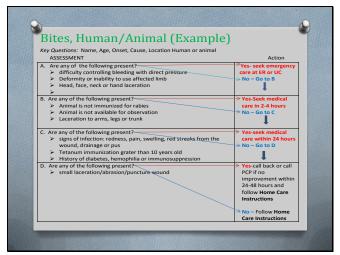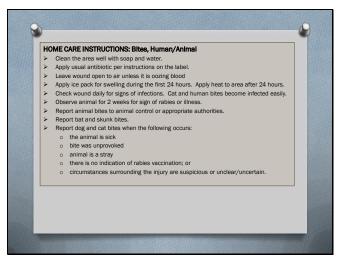## Have I overlooked anything?

SOURCE

Trauma
Infection
Stress
Other

Trauma

- Fall
- Bumped head
- MVA (Motor Vehicle Accident)
- Foreign body in orifice
- Twisting / straining / lifting
- Bites
- Burns

Bites, Human/Animal (Example)

Key Questions: Name, Age, Onset, Cause, Location Human or animal

ASSESSMENT	Action

A. Are any of the following present?
  ➢ difficulty controlling bleeding with direct pressure
  ➢ Deformity or inability to use affected limb
  ➢ Head, face, neck or hand laceration
	Yes- seek emergency care at ER or UC
	No – Go to B

B. Are any of the following present?
  ➢ Animal is not immunized for rabies
  ➢ Animal is not available for observation
  ➢ Laceration to arms, legs or trunk
	Yes-Seek medical care in 2-4 hours
	No – Go to C

C. Are any of the following present?
  ➢ signs of infection: redness, pain, swelling, red streaks from the wound, drainage or pus
  ➢ Tetanum immunization grater than 10 years old
  ➢ History of diabetes, hemophilia or immunosuppression
	Yes-seek medical care within 24 hours
	No – Go to D

D. Are any of the following present? ➢ small laceration/abrasion/puncture wound	**Yes**-call back or call PCP if no improvement within 24-48 hours and follow **Home Care Instructions** **No** – Follow **Home Care Instructions**

HOME CARE INSTRUCTIONS: Bites, Human/Animal

➢ Clean the area well with soap and water.
➢ Apply usual antibiotic per instructions on the label.
➢ Leave wound open to air unless it is oozing blood
➢ Apply ice pack for swelling during the first 24 hours. Apply heat to area after 24 hours.
➢ Check wound daily for signs of infections. Cat and human bites become infected easily.
➢ Observe animal for 2 weeks for sign of rabies or illness.
➢ Report animal bites to animal control or appropriate authorities.
➢ Report bat and skunk bites.
➢ Report dog and cat bites when the following occurs:
    o the animal is sick
    o bite was unprovoked
    o animal is a stray
    o there is no indication of rabies vaccination; or
    o circumstances surrounding the injury are suspicious or unclear/uncertain.

Trauma based rules of thumb

- Never remove impaled objects no matter how small
- Burns potentially may be worse than they initially appear
- Any jaw or face trauma is a head injury until proven otherwise

TRAUMA

Is it Abuse?

- Trauma should be considered abuse until proven otherwise if:
  - an injury is unexplained,
  - The injury is inconsistent with the reported mechanism of injury
  - the severity of the injury is incompatible with the history,
  - the history keeps changing, or
  - there is a delay is seeking medical care following an injury

Infection

- Fever
- Purulent discharge
- Discolored/malodorous urine
- Heat, redness, swelling
- Pain/dysuria
- Previously dx infectious disease
- Rashes (all are considered contagious until proven otherwise)
- Immunization status

Stress

- Stress-induced illness
  - Gastric hyperacidity
  - Tension headache
  - Irritable bowel syndrome
- Psychosomatic complaints
  - Give the consumer the benefit of the doubt
  - Use caution in "labeling" or stereotyping
- Post-traumatic stress disorder

Red Flags

- Severe, strange or suspicious symptoms
- Co-morbidities
- Pain that awakens or prevents sleep
- Debilitated (or challenged)
- Frequent flyers
- Repeat callers
- Poor historians
- Concerned aide/family/pt
- "Gut instinct"
- Extremes of age

Elderly

- Presentation may be atypical, silent or late
- Physiologic changes
- Impaired ADLs
- Altered LOC
  - Neurologic
  - Dehydration
  - Sepsis
  - Poly-pharmacy /adverse drug reactions
- Change from baseline

Considerations

- Age, gender, culture, ethnicity, education

- When last seen by provider / next appt?

- Access to care
  - Distance
  - Time of day
  - Transportation

Closing the Call

- "So this is what you told me…"
  - Read note to caller
- Plan collaboratively
- Have caller take notes!
- "Now, tell me what you plan to do"
  - (confirm understanding & intent to comply)
- "Are you comfortable with this plan?"
- Other questions or concerns?
- What to expect & call back instructions

Closing the loop

- Always follow up
  - To ensure that directions were followed and
  - Outcome: need to do anything else?
- Continuity of care: You are responsible until you "hand off"
  - To a higher level of care (ER, UC, etc.)
  - To the RN responsible for the site
    - Write e-mail and leave voice message on phone

Interviewing Pitfalls
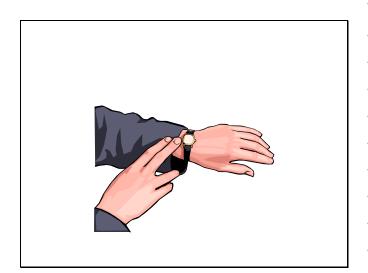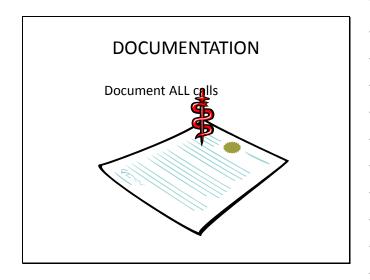
- Jumping to conclusion/stereotyping
- Being in a hurry; being distracted   (not thinking)
- Language related misunderstandings
- Evasive / uninformed caller
- CALLER-INITIATED DIAGNOSIS!

Remember…

- Overreacting is a GOOD thing

- ALWAYS err on the side of caution

If in doubt, send 'em out

DOCUMENTATION

Document ALL calls

**IF IT'S NOT WRITTEN,
IT DIDN'T HAPPEN!**

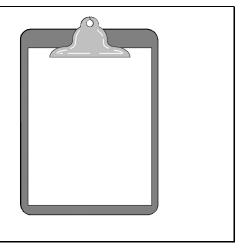**IF IT'S NOT WRITT...
IT DIDN'T HAPPE...**

Document ALL calls
Document all advice and instructions
Document all pertinent findings

Documenting

- Depending on your agency's system, information generally documented includes:
  - Who called
  - Chief complaint
  - Questions asked/answered
  - Protocol used (e.g. Briggs:Nausea/vomiting p 339)
  - Instructions given including follow up.

Your Note Should Paint a Picture of What You're Thinking and Why...

- Will it help you...

  - provide care to the person?

  - communicate with other healthcare personnel?

  - defend your actions in court?

And don't forget the

- Call tracking
- QA
- Legal record of calls not entered into medical record

RISK MANAGEMENT

Risk Management Tips

- Only RNs may be on call
- If you receive a call about the same person 2 or 3 times in 24 hours, the person should be seen.
- If the caller is concerned (or if you are concerned) the person should be seen.
- Follow policy/protocol unless it doesn't fit. Then deviate and document why.
- Watch for co-morbidities and high risk groups.

- Document thoroughly
- Be sure the caller understands what worse looks like
- Be sure caller knows what to do if the person doesn't get better.
- Perform regular quality assurance (continuity/follow-up)
- If in doubt, ALWAYS err on the side of caution!

What Prompts Lawsuits?

- Negative RN attitudes
- Lack of caring and concern
- Unwillingness/unavailability to communicate
- Dissatisfaction with handling of problems

Let's Talk Customer Relations

- Remember, they're worried...
- Don't take it personally
- Empathize
- Defuse
- Anger curve
- What are the consequences?
- GOLDEN RULE

TEST FOR LIABILITY

- Duty

- Breach of Duty

- Damages

- Causation

Duty

- Relationship must exist

Breach of Duty

- **Breach occurs if the practitioner fails the patient by not meeting the Standard of Care.**

- **Standard of Care is measured by what any reasonable, prudent practitioner would do under the same or similar circumstances.**

Damages

- A bad outcome?
- especially if the family (or family representative) is ANGRY!

Causation

- Who was negligent?
  - The Triage Nurse by doing something or failing to do something that resulted in the damages? (giving bad advice)
  - The agency nurse for not providing UAPs with appropriate training and supervision?
  - The UAP for willfully or otherwise failing to carry out the RN's instructions?

OOPS!

To Protect Yourself and Your Patient

- Follow protocol & document it (unless it isn't appropriate)

- Be sure the caller understands what to do if the person doesn't get better.

- Be sure the caller understands what worse looks like.

- If in doubt, ALWAYS err on the side of caution.

Common Causes of Lawsuits Failure to…

- Failure to provide for the consumer's safety (eg. falls)
- Failure to properly administer medications
- Failure to properly assess the patient
- Failure to communicate changes in the consumer's condition
- Failure to question orders & intervene through chain of command in timely fashion
- Failure to do procedures per proper standards
- Failure to document condition, treatment & response to treatment

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SO HOW DO YOU PROTECT YOURSELF?

1. Don't make mistakes
2. Pray for good outcomes!

Remember…

You are a nurse.

Every time you take care of a person, you are practicing nursing…

…even over the telephone!

Thank you, and Good Luck!

Contact information

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